SerendipPT Policies

Please do not type on this form. Print the form, fill it out and email it to me at info@serendipPT.com

General Information Today's Date: ________________________

Name_________________________________ Date of Birth _____________________________

Address _____________________ City_______________________State_____ Zip___________

Preferred Phone _________________ Home or Cell? Preferred Email ___________________

Contact In Case of Emergency (Name & Phone)_______________________________________

How did you learn of SerendipPT? ___ Friend ___ Physician Referral ___ Web Search ___Soul Society Yoga ___Yelp ___ Other:__________________________

Informed Consent for Treatment

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy, evaluation and treatment have been explained to you. As the client, I understand that I will receive information at the initial evaluation concerning the evaluation, treatment and options available for my condition. I consent to services at SerendipPT. In doing so, I understand that such therapy involves bodily contact, touching and/or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop any treatment at any time without fear of judgment or other repercussions. Patient Initials: ______

Payment

Payment is due at the time of service. We accept Major Credit cards, cash and checks. Please note, bounced checks will have a $30 charge, paid by the patient. If you have bounced 2 checks, you will need to provide an alternative payment. I have read and understood SerendipPT payment policy and I agree to be bound by its terms. I understand that terms may be amended by the practice. Patient Initials________

Insurance

We are out of network with all insurance companies. We can prepare an invoice for you to submit to your insurance company for reimbursement directly from the insurer. It is your responsibility to understand your contract with your insurance company and to obtain any reimbursements from your insurance company.

Cancellation Policy

We understand that unanticipated events happen occasionally. In our desire to be effective and fair to all our clients and out of consideration for our therapists' time, we have adopted the following policies:

> **Cancellations:** Our practice requires that if you have to cancel, it must be **24 hours** prior to your appointment; otherwise, you will be charged the price of a full treatment session. Appropriate forms of notifying the practice of your cancellation include email, phone call or voicemail.
>
> **No Shows:** Anyone who either forgets or consciously chooses to forgo his or her appointment for whatever reason will be considered a no-show and will be **charged the full treatment session** and future service will be denied until payment is made.
>
> **Arriving Late:** Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, you will be **charged the full treatment session.**

I have read and understand SerendipPT cancellation policies and I agree to be bound by its terms. Patient Initials: ________

Privacy/Information Exchange

SerendipPT maintains the privacy of patient health information. If you leave a text, phone or email message with your name and phone number, I will make every effort to respond within 4 hours during the work day or the next business day. I understand the risks inherent in using unsecured/unencrypted communications. I acknowledge that I may change my preference below at any time by notifying the practice in writing. Initial those that apply:

I authorize this practice to contact me via unsecured text _______
I authorize this practice to contact me unencrypted email _______

SerendipPT will send you periodic updates about activities at our office. These may include appointment reminders, changes in policies, new service offerings, newsworthy health research findings, newsletters, and special offers/invitations for events.

Please note: We will NEVER share your email address with anyone.

Reason for your visit

Describe below the reason for your visit to SerendipPT. What are your goals?

____
____
____

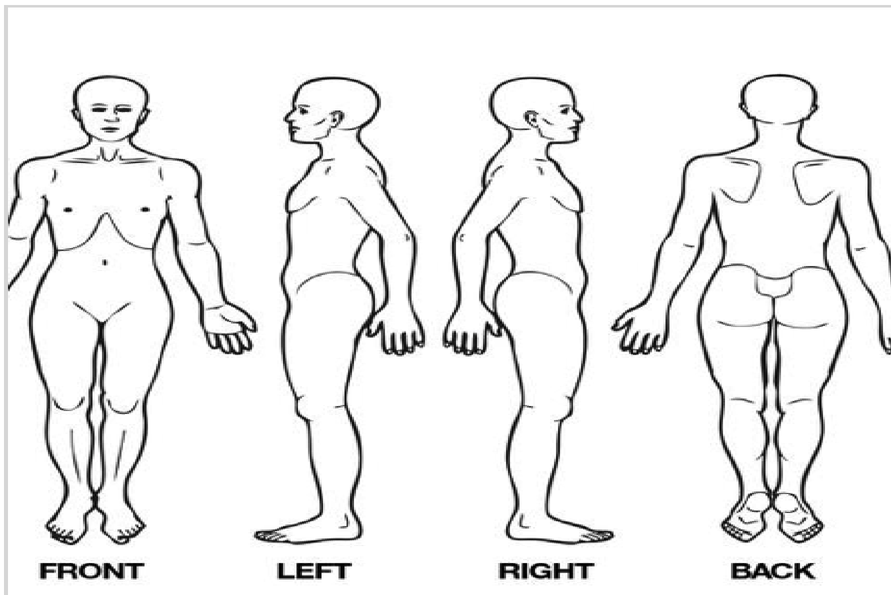
Was your first episode of the problem related to a specific event/injury? Yes or No?

Since then, has it: ______ Stayed the same? ______ Gotten worse? ______ Gotten better?

Have you had any other services to treat your problem? Yes or No? If yes, describe:

____
____
____

Please shade the areas of concern below:



What is the intensity of your pain, on a scale of 0-10; 0=no pain,10=Worst pain? ___________

Describe the symptoms (e.g., throbbing, aching, burning, numbness, weakness, occasional or constant) ____
____

Activities that cause or aggravate your symptoms:____________________________________
____

Health History

Have you ever had any of the following conditions or diagnoses? Circle all that apply:

Anemia	Low Back pain	Bone Fracture	Pelvic Fracture
Alcohol/Drug abuse	SI Joint Pain	Joint replacement	HIV
Heart problems	Tailbone Issue	Stroke	Anxiety
Cancer	Headache	Smoker	Pelvic Pain
Asthma	Jaw pain	Urinary Incontinence	Pacemaker
High Blood Pressure	Diabetes	Constipation	Ringing in Ears
Depression	Allergies	IBS	Malignancy/CA
Fibromyalgia	Arthritis	Abdominal pain	Currently pregnant?

Other health concerns: ____

Please list any surgeries and their dates:

____

____

____

Please list any medications you are currently taking:

Medication	For treatment of	Dose (amt/day)	Effectiveness

Thank you for your thoughtful time and attention.